

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) ROBERT EDWARD DERR			First Middle Last			2a. DATE OF DEATH JUNE 27 1968			2b. HOUR 8A M		
3. SEX M			4. RACE W			5. DATE OF BIRTH MARCH 24 1908			6. AGE (In years last birthday) 60 YRS.		
7a. BIRTHPLACE (State or foreign country) Massachusetts			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Howard		
10. CITY OR TOWN OF DEATH Laurel			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rt 1 Box 200			12a. USUAL OCCUPATION (Kind of work done during most of working life (not retired)) model carner-operation			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md			13b. COUNTY Howard			13c. CITY OR TOWN Laurel			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER Rt 1 Box 200			14. FATHER'S NAME First Middle Last Ralph Derr			15. MOTHER'S MAIDEN NAME First Middle Last Emma Schaefer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 281-26-2459			17. INFORMANT Ruth W. Derr			17b. ADDRESS Box 200 Laurel Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (c) Arteriosclerosis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 260X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 1960			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from June 27, 1968 , 19 1968 , that (I) (we) last saw the deceased alive on June 27, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert W. Wingfield, M.D.			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED June 28, 1968		
22d. PHYSICIAN'S NAME (Type) ROBERT W. WINGFIELD, M.D.			22e. ADDRESS Laurel, Maryland								
23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) Burial			23b. DATE 7-1-68			23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem			23d. LOCATION (City or Town) (County) (State) Dayton Mount Ohio		
24. FUNERAL DIRECTOR De Witt Darnedean			ADDRESS Laurel Md			25a. REC'D BY REGISTRAR MDL - 3 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(Faint handwritten notes at the bottom of the page)

ad - proof - ad - proof

Handwritten: *Ball, 22 April 1911*
all 12 April 1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Howard M Duvall			2a. DATE OF DEATH Month 6 Day 1 Year 68		2b. HOUR 3 a M
3. SEX Male		4. RACE White		5. DATE OF BIRTH Jan. 23, 1884	
6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Howard Md.					
10. CITY OR TOWN OF DEATH Florence		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R#2, Woodbine		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Florence	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER R#2, Woodbine			
14. FATHER'S NAME First Middle Last Oath Duvall			15. MOTHER'S MAIDEN NAME First Middle Last Emma Hobbs		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 215-32-1198		17. INFORMANT Address Forest B. Duvall, R# 2, Woodbine, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4221 (b) Chr. Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) A.S.C.V.D.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 4 yrs. 10 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Prostrate Ca.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work _____ at work _____		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____	
22a. I certify that (I) (this hospital) attended the deceased from July 29 , 19 59 , to June 1 , 19 68 , that (I) (we) last saw the deceased alive on May 25 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.					
22b. SIGNATURE Sani Okutman DEGREE _____				22c. DATE SIGNED June 1, 1968	
22d. PHYSICIAN'S NAME (Type) Sani Okutman, M.D.				22e. ADDRESS Obrecht Road, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 3, 1968		23c. NAME OF CEMETERY OR CREMATORY Jennings Chapel	
23d. LOCATION (City or Town) (County) (State) Florence, Md.					
24. FUNERAL DIRECTOR ADDRESS Olin L. Molesworth, Damascus, Md.				25a. REC'D BY REGISTRAR DATE JUN 4 1968	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
MARY			C. ECKER			June 7 1968		11:55 P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR	
Female		White		Aug. 6, 1899		68 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Virginia		U.S.A.				Howard			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
rural-Mt. Airy			Rt. 3			housewife		home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland			Howard			Mt. Airy		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER			
First Middle Last			First Middle Last			Route #3			
Ashley Dinges			Emily Funk						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT		Address	
no			217-46-2240			Mrs. Wilbur Spurrier		Mt. Airy, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Generalized Arteriosclerosis									10 years
2509 DUE TO, OR AS A CONSEQUENCE OF									
(b) Diabetes Mellitus									16 years
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
260X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from Aug. 1957 to June, 1968, that (I) (we) lost saw the deceased alive on June 7 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE								22c. DATE SIGNED	
W.B. Culwell, MD								June 8, 1968	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
W.B. Culwell				900 So. Main St Mt. Airy, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
BURIAL		June 11, 1968		Pine Grove		Mt. Airy, Maryland			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
C.M. Waltz, Box 241, Sykesville, Md.						DATE JUN 11 1968		Charles Judge	

MEDICAL CERTIFICATION

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8018

(continued)

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1998, 2000, 2002, 2004, 2006, 2008, 2010, 2012, 2014, 2016, 2018, 2020, 2022, 2024, 2026, 2028, 2030, 2032, 2034, 2036, 2038, 2040, 2042, 2044, 2046, 2048, 2050, 2052, 2054, 2056, 2058, 2060, 2062, 2064, 2066, 2068, 2070, 2072, 2074, 2076, 2078, 2080, 2082, 2084, 2086, 2088, 2090, 2092, 2094, 2096, 2098, 2100, 2102, 2104, 2106, 2108, 2110, 2112, 2114, 2116, 2118, 2120, 2122, 2124, 2126, 2128, 2130, 2132, 2134, 2136, 2138, 2140, 2142, 2144, 2146, 2148, 2150, 2152, 2154, 2156, 2158, 2160, 2162, 2164, 2166, 2168, 2170, 2172, 2174, 2176, 2178, 2180, 2182, 2184, 2186, 2188, 2190, 2192, 2194, 2196, 2198, 2200, 2202, 2204, 2206, 2208, 2210, 2212, 2214, 2216, 2218, 2220, 2222, 2224, 2226, 2228, 2230, 2232, 2234, 2236, 2238, 2240, 2242, 2244, 2246, 2248, 2250, 2252, 2254, 2256, 2258, 2260, 2262, 2264, 2266, 2268, 2270, 2272, 2274, 2276, 2278, 2280, 2282, 2284, 2286, 2288, 2290, 2292, 2294, 2296, 2298, 2300, 2302, 2304, 2306, 2308, 2310, 2312, 2314, 2316, 2318, 2320, 2322, 2324, 2326, 2328, 2330, 2332, 2334, 2336, 2338, 2340, 2342, 2344, 2346, 2348, 2350, 2352, 2354, 2356, 2358, 2360, 2362, 2364, 2366, 2368, 2370, 2372, 2374, 2376, 2378, 2380, 2382, 2384, 2386, 2388, 2390, 2392, 2394, 2396, 2398, 2400, 2402, 2404, 2406, 2408, 2410, 2412, 2414, 2416, 2418, 2420, 2422, 2424, 2426, 2428, 2430, 2432, 2434, 2436, 2438, 2440, 2442, 2444, 2446, 2448, 2450, 2452, 2454, 2456, 2458, 2460, 2462, 2464, 2466, 2468, 2470, 2472, 2474, 2476, 2478, 2480, 2482, 2484, 2486, 2488, 2490, 2492, 2494, 2496, 2498, 2500, 2502, 2504, 2506, 2508, 2510, 2512, 2514, 2516, 2518, 2520, 2522, 2524, 2526, 2528, 2530, 2532, 2534, 2536, 2538, 2540, 2542, 2544, 2546, 2548, 2550, 2552, 2554, 2556, 2558, 2560, 2562, 2564, 2566, 2568, 2570, 2572, 2574, 2576, 2578, 2580, 2582, 2584, 2586, 2588, 2590, 2592, 2594, 2596, 2598, 2600, 2602, 2604, 2606, 2608, 2610, 2612, 2614, 2616, 2618, 2620, 2622, 2624, 2626, 2628, 2630, 2632, 2634, 2636, 2638, 2640, 2642, 2644, 2646, 2648, 2650, 2652, 2654, 2656, 2658, 2660, 2662, 2664, 2666, 2668, 2670, 2672, 2674, 2676, 2678, 2680, 2682, 2684, 2686, 2688, 2690, 2692, 2694, 2696, 2698, 2700, 2702, 2704, 2706, 2708, 2710, 2712, 2714, 2716, 2718, 2720, 2722, 2724, 2726, 2728, 2730, 2732, 2734, 2736, 2738, 2740, 2742, 2744, 2746, 2748, 2750, 2752, 2754, 2756, 2758, 2760, 2762, 2764, 2766, 2768, 2770, 2772, 2774, 2776, 2778, 2780, 2782, 2784, 2786, 2788, 2790, 2792, 2794, 2796, 2798, 2800, 2802, 2804, 2806, 2808, 2810, 2812, 2814, 2816, 2818, 2820, 2822, 2824, 2826, 2828, 2830, 2832, 2834, 2836, 2838, 2840, 2842, 2844, 2846, 2848, 2850, 2852, 2854, 2856, 2858, 2860, 2862, 2864, 2866, 2868, 2870, 2872, 2874, 2876, 2878, 2880, 2882, 2884, 2886, 2888, 2890, 2892, 2894, 2896, 2898, 2900, 2902, 2904, 2906, 2908, 2910, 2912, 2914, 2916, 2918, 2920, 2922, 2924, 2926, 2928, 2930, 2932, 2934, 2936, 2938, 2940, 2942, 2944, 2946, 2948, 2950, 2952, 2954, 2956, 2958, 2960, 2962, 2964, 2966, 2968, 2970, 2972, 2974, 2976, 2978, 2980, 2982, 2984, 2986, 2988, 2990, 2992, 2994, 2996, 2998, 3000, 3002, 3004, 3006, 3008, 3010, 3012, 3014, 3016, 3018, 3020, 3022, 3024, 3026, 3028, 3030, 3032, 3034, 3036, 3038, 3040, 3042, 3044, 3046, 3048, 3050, 3052, 3054, 3056, 3058, 3060, 3062, 3064, 3066, 3068, 3070, 3072, 3074, 3076, 3078, 3080, 3082, 3084, 3086, 3088, 3090, 3092, 3094, 3096, 3098, 3100, 3102, 3104, 3106, 3108, 3110, 3112, 3114, 3116, 3118, 3120, 3122, 3124, 3126, 3128, 3130, 3132, 3134, 3136, 3138, 3140, 3142, 3144, 3146, 3148, 3150, 3152, 3154, 3156, 3158, 3160, 3162, 3164, 3166, 3168, 3170, 3172, 3174, 3176, 3178, 3180, 3182, 3184, 3186, 3188, 3190, 3192, 3194, 3196, 3198, 3200, 3202, 3204, 3206, 3208, 3210, 3212, 3214, 3216, 3218, 3220, 3222, 3224, 3226, 3228, 3230, 3232, 3234, 3236, 3238, 3240, 3242, 3244, 3246, 3248, 3250, 3252, 3254, 3256, 3258, 3260, 3262, 3264, 3266, 3268, 3270, 3272, 3274, 3276, 3278, 3280, 3282, 3284, 3286, 3288, 3290, 3292, 3294, 3296, 3298, 3300, 3302, 3304, 3306, 3308, 3310, 3312, 3314, 3316, 3318, 3320, 3322, 3324, 3326, 3328, 3330, 3332, 3334, 3336, 3338, 3340, 3342, 3344, 3346, 3348, 3350, 3352, 3354, 3356, 3358, 3360, 33

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THE UNIVERSITY OF CHICAGO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, detach and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|--|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
MARGARET P. FUCHS | | | | | 2a. DATE OF DEATH
June 28, Month 1968 Day Year | | | 2b. HOUR
M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
February 3, 1889 | | 6. AGE (In years last birthday) YRS.
79 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Howard Md. | | | |
| 10. CITY OR TOWN OF DEATH
Elkridge | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
1723 Levering Avenue | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Howard | | 13c. CITY OR TOWN
Elkridge | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
1723 Levering Avenue | |
| 14. FATHER'S NAME First Middle Last
Rudolph Breitenbach | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Louisa Henninger | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT Address Ave.
Mrs. Marguerite G. Cochrane, 1723 Levering | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) General atherosclerosis with
437.0 DUE TO, OR AS A CONSEQUENCE OF Reperfusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF Reperfusion
(c) Cerebral vascular thrombosis
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
334.X | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
74.0
174.0 | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.
19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 28, 1968 , to June 28, 1968 , that (I) (we) lost saw the deceased alive on June 28, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Frederick J. Beitler | | | | 22c. DATE SIGNED
6-29-68 | | | | | |
| 22d. - PHYSICIAN'S NAME (Type) Dr. Frederick Beitler | | | | 22e. ADDRESS 1014 Francis Avenue, Balto., Md. 21227 | | | | | |
| 23a. BURIAL, CREMATION, SPECIFY
BURIAL | | 23b. DATE
7-1-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Grace Episcopal Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Elkridge, Howard County, Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | | 25a. REC'D BY REGISTRAR
JUL - 3 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form WH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|---------|------------------|--|--------------------------------|--|---|--|--------------------------|---|--|----------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| THOMAS | | | LEE | | | McCLAIN | | | June 10 19 68 | | |
| 3 SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR |
| Male | Colored | 2-18-03 | 65 YRS | | | | | June 14 1968 | | | 11 A |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Maryland | | | U.S.A. | | | | | | Howard Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Jessup | | | Box 280 Washington Blvd. | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| Md. | | | Howard | | | Jessup | | | Box 280 Washington Blvd. | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| unknown | | | unknown | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or <u>unknown</u>) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Undetermined because of advanced decomposition</u>
DUE TO, OR AS A CONSEQUENCE OF of body
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>7955</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town County State | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | EXAMINER'S NAME (Type) | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | |
| <i>Edward F. Wilson</i> | | | Edward F. Wilson, M.D. | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | June 14, 1968 | | |
| EXAMINER'S NAME (Type) | | | 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | |
| | | | Burial | | | 6-19-68 | | | Mt Zion Cemetery | | |
| 24. FUNERAL DIRECTOR | | | 23d. LOCATION (City or Town) (County) (State) | | | 23e. REC'D BY REGISTRAR | | | 23f. REGISTRAR'S SIGNATURE | | |
| Robert L. Snowden | | | Bartontown, Md | | | JUN 25 1968 | | | <i>Charles Judge</i> | | |

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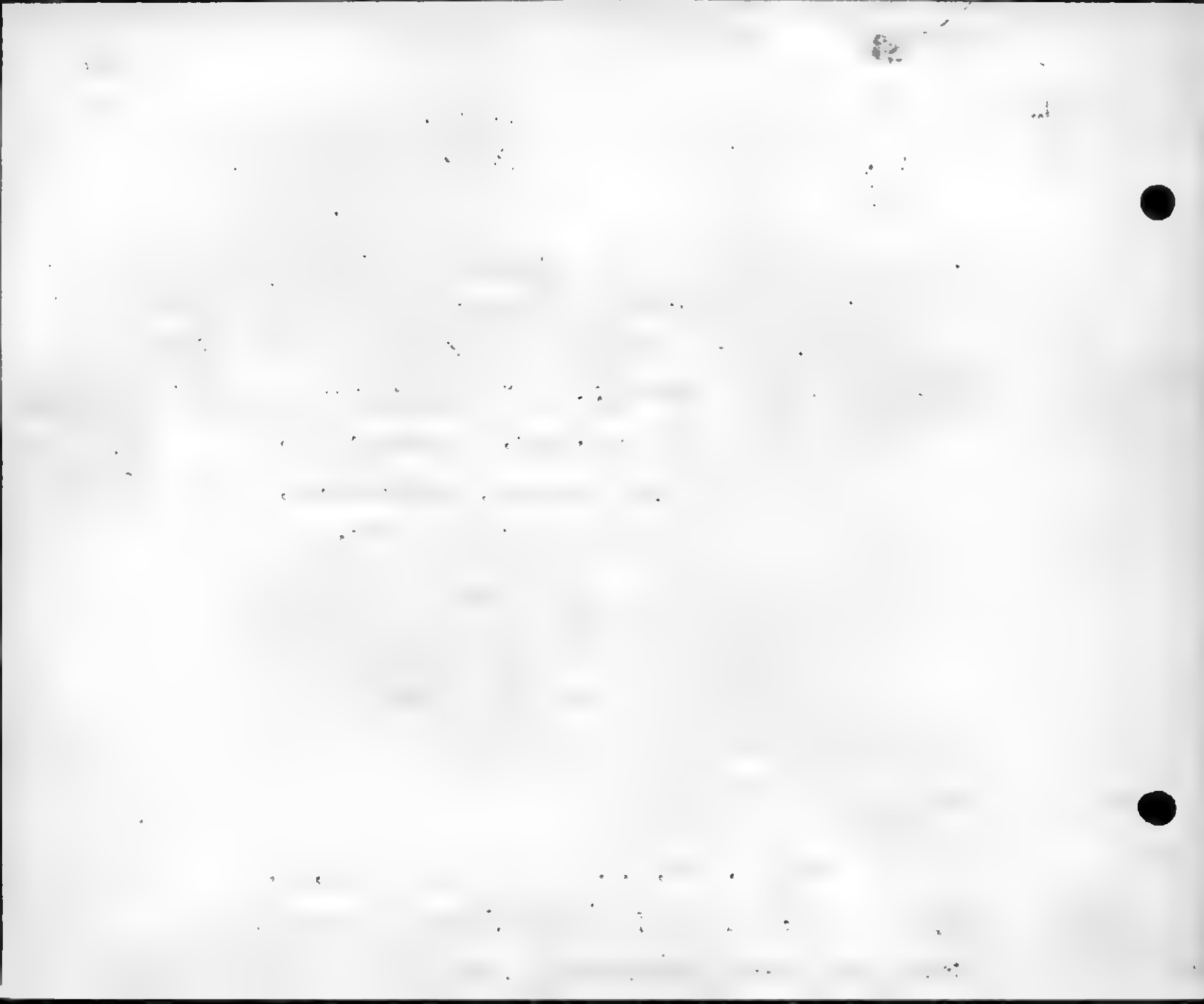
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|---|--|--|---|---|--|---|--|--|--|---|--------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
DAISY S. McNulty | | | | | | 2a. DATE OF DEATH Month Day Year
JUNE 24 1968 | | | 2b. HOUR
9:30 P.M. | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MARCH 3, 1885 | | | 6. AGE (In years last birthday)
83 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
HOWARD Md | | | | | | |
| 10. CITY OR TOWN OF DEATH
SYkesville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Route 32 | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Seamstress | | | 12b. KIND OF BUSINESS OR INDUSTRY
Sewing | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
Md. | | 13b. COUNTY
HOWARD | | 13c. CITY OR TOWN
SYkesville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
Route 32 | | | | |
| 14. FATHER'S NAME First Middle Last
Franklin E. Selby | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Ida - Blackston | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
No | | 16b. SOCIAL SECURITY NO.
162 09 6204 | | 17. INFORMANT
Mrs Agnes Dorsey | | | | Address
Sykesville Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerosis, generalized; ASHD,
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary thrombosis, cardiac failure,
DUE TO, OR AS A CONSEQUENCE OF
(c) Cardiac arrest and pylora spasm. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
March 1968 through 6/24/68 | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March , 19 68 , to 6/24/68 , 19 68 , that (I) (we) last saw the deceased alive on 6/24/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Howard E. Hall | | | | | | DEGREE ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
6/26/68 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Howard E. Hall, M.D. | | | | | | 22e. ADDRESS
Sykesville, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
6-27-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Carmel Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Littlestown PA. | | | | | | |
| 24. FUNERAL DIRECTOR
Harry W. Haight | | | | | | ADDRESS
Sykesville, Md. | | 25a. REC'D BY REGISTRAR
JUN 28 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

MEDICAL CERTIFICATION

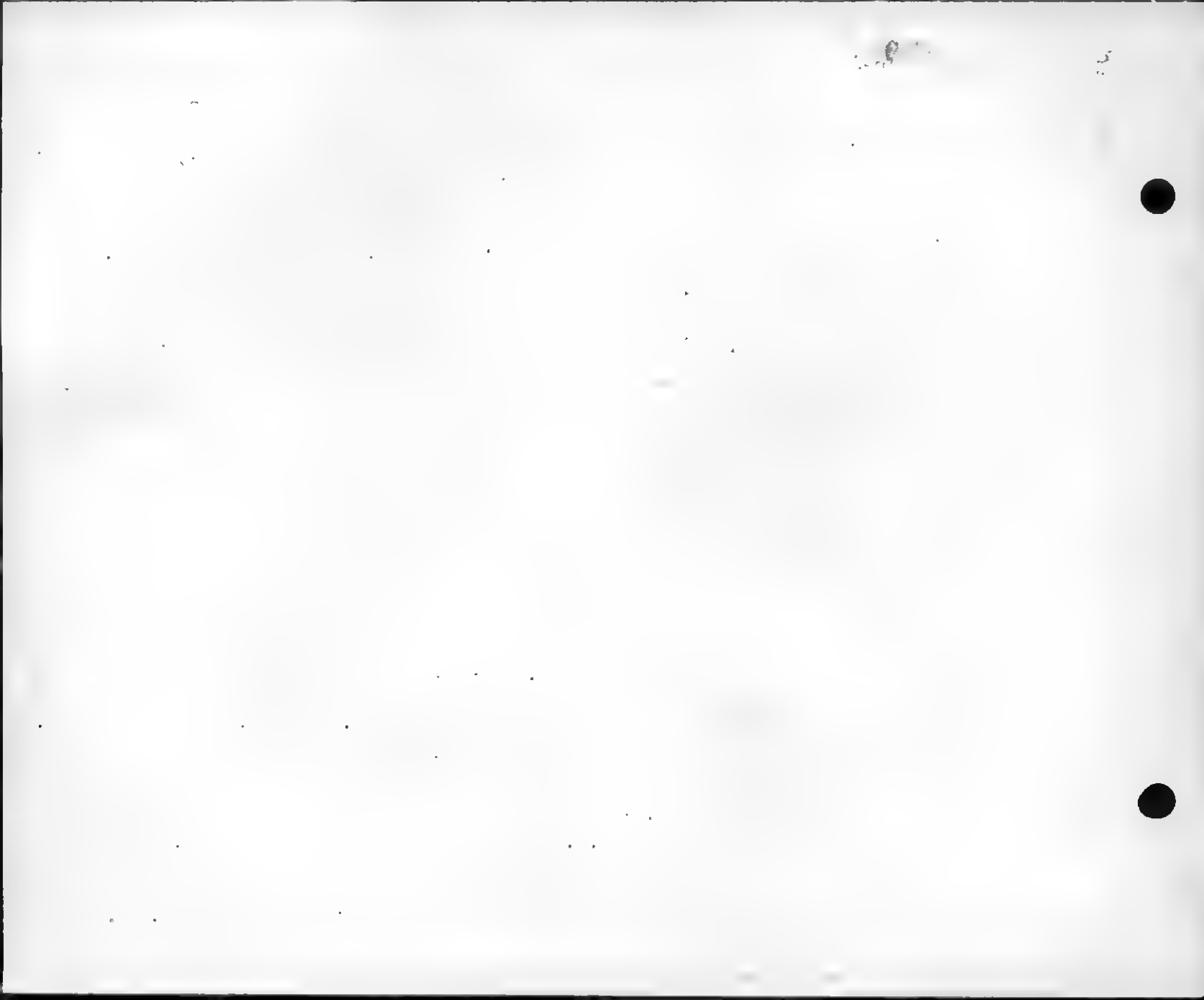


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10M-999. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|------------------------|---|---|--|-----------------------------------|---|-----------------------------------|--|-------------------------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED-NAME
(Type or Print) | | First
JOSEPH | | Middle
STANISLAUS | | Last
MICHNO | | 2a DATE KNOWN OF DEATH
Month 6 Day 1 Year 1968 | |
| 3 SEX
Male | 4 RACE
White | 5 DATE OF BIRTH
March 31, 1927 | 6 AGE (in years last birthday)
41 YRS | 7 UNDER YEAR
MONTHS
41 | 8 UNDER YEAR
DAYS
41 | 9 UNDER YEAR
HOURS
41 | 10 UNDER YEAR
MIN
41 | 2c DATE PRONOUNCED DEAD
Month June Day 2 Year 1968 | 2d HOUR
12:10 |
| 7a BIRTHPLACE (State or foreign country)
Baltimore | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
HOWARD | | | |
| 10 CITY OR TOWN OF DEATH
Ellicott City | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
106 Old Fence Rd. | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Real Estate Mg. | | 12b KIND OF BUSINESS OR INDUSTRY
Wld. RR | |
| 13a USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
Md | | 13b COUNTY
HOWARD | | 13c CITY OR TOWN
Ellicott City | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER
106 Old Fence Road | |
| 14 FATHER'S NAME
First Joseph A. Middle Michno Last Michno | | | | 15. MOTHER'S MAIDEN NAME
First Theresa Middle Wojciechowski Last Wojciechowski | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
yes | | (If yes give war or dates of service)
WWII | | 16b SOCIAL SECURITY NO
218-22-9688 | | 17 INFORMANT
ADDRESS
Mrs Rita Michno 106 Old Fence Rd. Ellicott City | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART 1 DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Asphyxia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hanging
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
974x | | | | | | | | | |
| 19a DATE OF OPERATION
953x | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 6-1 19 68 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
Hanged self | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
home | | 21f LOCATION Street or R.F.D. No
106 Old Fence Rd. Ellicott City Howard Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
Charles S. Springate | | EXAMINER'S NAME (Type)
Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b DATE SIGNED
June 2, 1968 | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b DATE
June 5, 1968 | | 23c NAME OF CEMETERY OR CREMATORY
Crest Lawn Cemetery | | 23d LOCATION (City or Town) (County) (State)
Howard County, Md. | | 25a REC'D BY REGISTRAR
DATE JUN 5 1968 | |
| 24 FUNERAL DIRECTOR
Starling Funeral Estate
736 Edmondson Ave.
Catonville, Md. 21228 | | | | 25b REGISTRAR'S SIGNATURE
Charles Judge | | | | | |



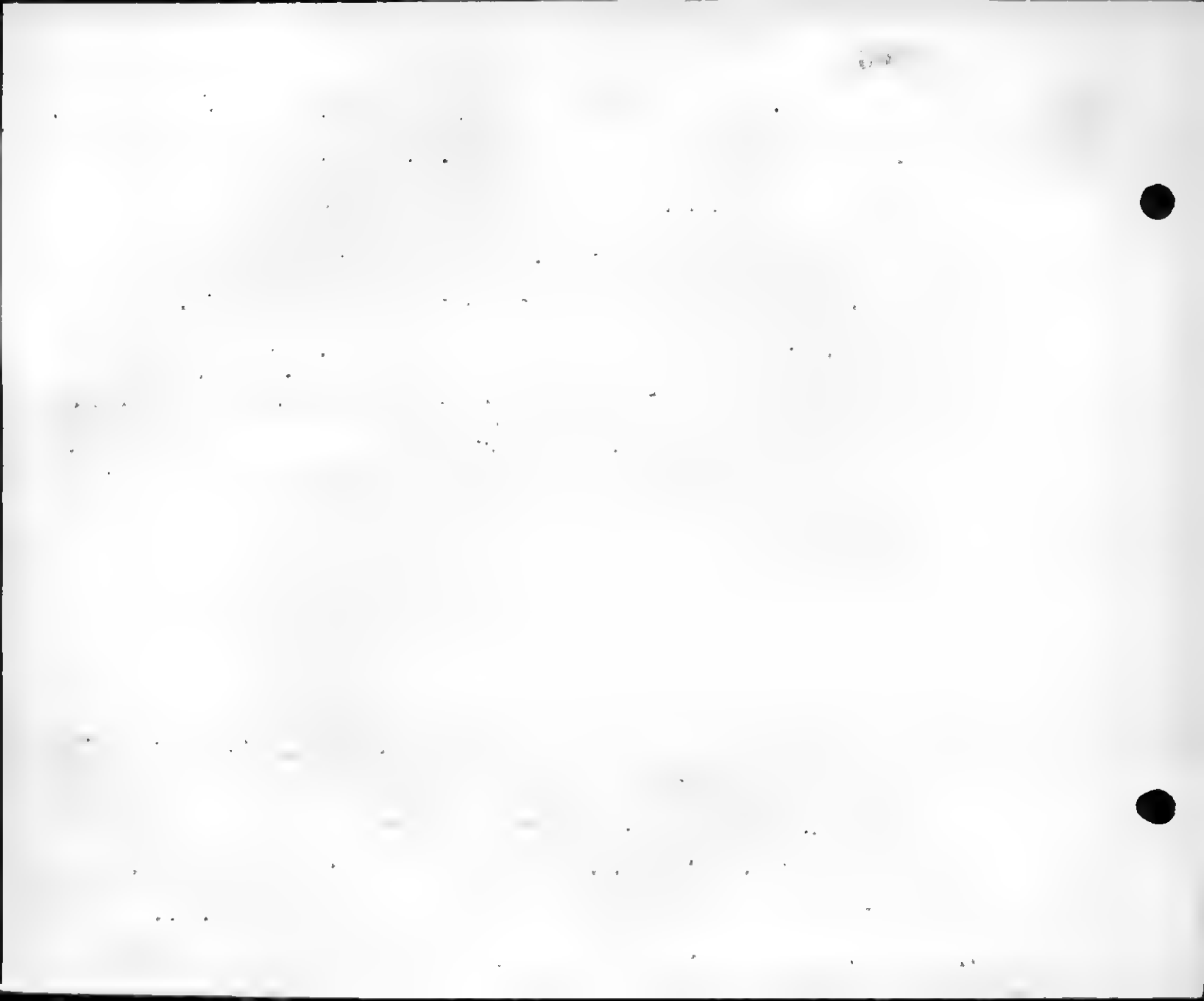
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and return them to the funeral director. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-2
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | |
|---|---|---|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month <u>6</u> Day <u>15</u> Year <u>68</u> | 2b. HOUR
<u>6:15 P.M.</u> |
| Margaret | | Mary | Mooney | | | |
| 3. SEX
<u>female</u> | 4. RACE
<u>white</u> | 5. DATE OF BIRTH
<u>Sept. 3, 1887</u> | | 6. AGE (In years
last birthday)
<u>80</u> YRS | 7. UNDER 1 YEAR
MONTHS <u> </u> DAYS <u> </u> | IF UNDER 24 HRS.
HOURS <u> </u> M.N. <u> </u> |
| 7a. BIRTHPLACE (State or foreign
country)
<u>Maryland</u> | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>Howard</u> Md. | | |
| 10. CITY OR TOWN OF DEATH
<u>Ellicott City</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
<u>Shaeffers N. H.</u> | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
<u>at home</u> | | 12b. KIND OF BUSINESS OR
INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution
admission) STATE
<u>Md.</u> | | 13b. COUNTY
<u>Howard</u> | 13c. CITY OR TOWN
<u>Ellicott City</u> | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER
<u>153 Main St.</u> | |
| 14. FATHER'S NAME
First <u>John D. Mooney</u> Middle <u> </u> Last <u> </u> | | | 15. MOTHER'S MAIDEN NAME
First <u>Mary E. Sweeney</u> Middle <u> </u> Last <u> </u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
<u>none</u> | | 17. INFORMANT
<u>Mrs. Tresia Stigler</u> Address <u>107 Hayfield Dr., Ellicott City, Md.</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Pleural effusion</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Carcinoma, chest, metastatic</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u> </u>
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>1 wk</u>
<u>1 yr.</u> |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. <u> </u> Month <u> </u> Day <u> </u> Year <u>1968</u>
P.M. <u> </u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. <u> </u> City or Town <u> </u> County <u> </u> State <u> </u> | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>2-22</u> , 19 <u>62</u> to <u>6-15</u> , 19 <u>68</u> , that (1) (we) last
saw the deceased alive on <u>6-15</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<u>Thomas F. Herbert M.D.</u> | | | | 22c. DATE SIGNED
<u>6-18-68</u> | | 22d. PHYSICIAN'S
NAME (Type)
<u>Thomas F. Herbert M.D.</u> |
| 22e. ADDRESS
<u>Church Rd., Ellicott City, Md.</u> | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVING <u>burial</u> | | 23b. DATE
<u>6/19/68</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>New Cathedral</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Md.</u> |
| 24. FUNERAL DIRECTOR
<u>John R. Slack</u> | | ADDRESS
<u>Ellicott City, Md.</u> | | 25a. REC'D BY REGISTRAR
<u>JUN 24 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>James J. Judge</u> |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08541

08546

| | | | | | | | | | | |
|---|--|--|---|---|---|---|---|---|--|--|
| 1. DECEASED NAME
(Type or print) JOHN F. O'NEILL | | | First Middle Last | | 2a. DATE OF DEATH
Month 6 Day 22 Year 68 | | 2b. HOUR
9:15 M | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
2-19-89 | | 6. AGE (In years last birthday)
79 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
HOWARD CO. Md. | | | | |
| 10. CITY OR TOWN OF DEATH
ELLICOTT CITY | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SHAFFERS CONV. RETREAT | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Ret. Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY
Farming | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD. | | | 13b. COUNTY
Howard | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
2508 WILKENS AVE. | |
| 14. FATHER'S NAME First Middle Last
Thomas O'Neill | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Annie Cooney | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No. | | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT Address
Bessie M. O'Neill, 2508 Wilkens Ave. 21223 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ch Congestive Heart failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Hypertensive Complications
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 yr.
3 yrs | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
443X | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, natify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Frank E. Shipley, M.D. | | | | | 22c. DATE SIGNED | | | 22d. PHYSICIAN'S NAME (Type)
FRANK E. SHIPLEY | | |
| 22e. ADDRESS
11 BALTO. AVE., SAVAGE, MD. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
6-25-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Washington Blvd. Howard Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS
HOWARD H. HUBBARD 4107 WILKENS AVE. 21229 | | | | | 25a. REC'D BY REGISTRAR
DATE JUN 25 1968 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

100

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the death certificate. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--------------------------------------|---|--|
| <p>Items 18, 22a film 402
7-26-68 mt</p> <p>Item 2a, Film 403
7-26-68 mt</p> <h2 style="text-align: center;">MEDICAL EXAMINER'S CERTIFICATE OF DEATH</h2> | | | | | | | | | | | |
| <p>1. DECEASED-NAME (Type or Print) CHARLES C. TUCKER</p> | | | | | | <p>2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month June Day 16 Year 1968</p> <p>2b. HOUR M</p> | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH 5/9/18 | | 6. AGE (In years last birthday) 50 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Howard Md. | | |
| 10. CITY OR TOWN OF DEATH Elkridge | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6112 Old Blvd. | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Painter | | 12b. KIND OF BUSINESS OR INDUSTRY Paint | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | | | | 13b. COUNTY Howard | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET AND NUMBER 6112 Old Washington Blvd. | |
| 14. FATHER'S NAME First Reuban Middle Tucker Last Tucker | | | | 15. MOTHER'S MAIDEN NAME First Florence Middle Nusbaum Last Nusbaum | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | | 16b. SOCIAL SECURITY NO. 218 03 5160 | | 17. INFORMANT Frances Tucker | | 17a. ADDRESS 6112 Old Wash. Blvd Elkridge 21227, Md. | | | |
| <p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART 1. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) Generalized convulsion</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(b) etiology undetermined</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c) </p> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)</p> <p>7802</p> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| <p>22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE Charles S. Springate M.D.</p> <p>EXAMINER'S NAME (Type) Charles S. Springate, M.D.</p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p> <p>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>DEPUTY MEDICAL EXAMINER <input type="checkbox"/></p> <p>ADDRESS (Street, city, town, or county) </p> <p>22b. DATE SIGNED June 17, 1968</p> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 23b. DATE 6/20/68 | | 23c. NAME OF CEMETERY OR CREMATORY Good Shepherd | | | | 23d. LOCATION (City or Town) (County) (State) Ellicott City, Md. | | | |
| 24. FUNERAL DIRECTOR Highbottom Slack Funeral Home ADDRESS Ellicott City, Md. | | | | | | 25a. REC'D BY REGISTRAR JUN 24 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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